

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Maryhaven Nursing and Rehabilitation Center
(CCN: 14-5741),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-125

Decision No. CR2798

Date: May 23, 2013

DECISION

Petitioner, Maryhaven Nursing and Rehabilitation Center, was not in substantial compliance with program participation requirements due to a violation of 42 C.F.R. § 483.25(h)¹ that posed a risk for minimal harm as alleged by the complaint investigation completed on August 17, 2011. The proposed enforcement remedy, a \$10,000 per-instance civil money penalty (PICMP), is reasonable. Petitioner is also ineligible to conduct a nurse aide training and competency evaluation program (NATCEP) for two years by operation of law.

¹ References are to the 2010 version of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

I. Background

Petitioner is located in Glenview, Illinois, and participates in Medicare as a skilled nursing facility (SNF) and in the state Medicaid program as a nursing facility (NF). On August 17, 2011, the Illinois Department of Public Health (state agency) completed a complaint investigation at Petitioner's facility and found that Petitioner was not in substantial compliance with two program participation requirements. Joint Stipulation of Facts (Jt. Stip.) ¶ 31; Centers for Medicare and Medicaid Services (CMS) Exhibit (Ex.) 3. CMS notified Petitioner by letter dated September 22, 2011, that CMS was imposing a PICMP of \$10,000 based only on Petitioner's violation of 42 C.F.R. § 483.25(h).² CMS Ex. 1 at 6. CMS also notified Petitioner that it was ineligible to conduct a NATCEP for two years following the survey. CMS Ex. 1 at 7.

On October 5, 2011, Petitioner requested a hearing before an administrative law judge (ALJ). The case was assigned to me for hearing and decision on October 13, 2011, and an Acknowledgement and Prehearing Order was issued at my direction. Petitioner filed a second request for hearing on November 18, 2011, which was docketed and consolidated with Petitioner's initial request for hearing. On July 12, 2012, I convened a hearing by video teleconference in Washington, D.C. and Chicago, Illinois. A transcript (Tr.) of the proceedings was prepared and is part of the record of this case. CMS offered CMS Exs. 1 through 18 that were admitted as evidence. Tr. 24. Petitioner offered Petitioner exhibits (P. Exs.) 19 through 41; P. Exs. 21, 24, and 39 were withdrawn, and the remaining exhibits were admitted as evidence. Tr. 26-28. CMS called Surveyor Jun Daryl Esuerte, RN, as a witness. Petitioner called Anne Schnur, LPN, as a witness. Following the hearing, the parties filed post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply and P. Reply).

² The September 22, 2011, CMS notice also advised Petitioner that a discretionary denial of payment for new admissions (DPNA) was imposed effective September 13, 2011 and that termination of Petitioner's provider agreement would occur on January 15, 2012. CMS Ex. 1 at 4-5. The CMS notice dated November 8, 2011, advised Petitioner that the DPNA effective September 13, 2011 was rescinded and that the termination would not be effectuated because Petitioner returned to substantial compliance on August 17, 2011. CMS Ex. 1 at 1.

II. Discussion

A. Issues

1. Whether there is a basis for the imposition of an enforcement remedy; and
2. Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are at section 1819 of the Social Security Act (Act) and 42 C.F.R. pt. 483. Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.³ The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory denial of payments for new admissions (DPNA). Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a noncompliant SNF’s participation in Medicare, even if there has been less than 180 days of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. “*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.” 42 C.F.R.

³ Participation of a NF in Medicaid is governed by section 1919 of the Act. Section 1919(h)(2) of the Act gives enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

§ 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. pt. 483, subpt. B. Noncompliance refers to any deficiency that causes a facility not to be in substantial compliance. 42 C.F.R. § 488.301. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS is authorized to impose a CMP for the number of days of noncompliance – a per day CMP – or for each instance of noncompliance – a PICMP. 42 C.F.R. § 488.430. The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, \$3,050 per day to \$10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). “*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” 42 C.F.R. § 488.301 (emphasis in original). The lower range of CMPs, \$50 per day to \$3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). The only range for a PICMP is \$1,000 to \$10,000. 42 C.F.R. §§ 488.408, 488(a)(2).

Petitioner was notified in this case that it was ineligible to conduct a NATCEP for two years. CMS Ex. 1 at 7. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have completed a training and competency evaluation program. Pursuant to sections 1819(f)(2) and 1919(f)(2) of the Act, the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements that the Secretary established and a process for reviewing and re-approving those programs using criteria the Secretary set. The Secretary promulgated regulations at 42 C.F.R. pt. 483, subpt. D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (f), a state may not approve and must withdraw any prior approval of a NATCEP offered by a skilled nursing or nursing facility that has been: (1) subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) assessed a CMP of not less than \$5,000; or (3) subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of “substandard quality of care” during a standard or abbreviated standard survey and involve evaluating additional participation requirements. “Substandard quality of care” is identified by the situation where surveyors identify one

or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a “certification of noncompliance leading to an enforcement remedy.” 42 C.F.R. § 488.408(g)(1), 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility’s authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, “must be upheld unless it is clearly erroneous.” 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The hearing before an ALJ is a de novo proceeding, i.e., “a fresh look by a neutral decision-maker at the legal and factual basis for the deficiency findings underlying the remedies.” *Life Care Center of Bardstown*, DAB No. 2479 at 32 (2012) (citation omitted). The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App’x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998);

Hillman Rehab. Ctr., DAB No. 1611 (1997)(*remand*), DAB No. 1663 (1998) (*aff. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. The parties stipulated prior to hearing that the only deficiency at issue is the alleged noncompliance cited as a violation of 42 C.F.R. § 483.25(h) (Tag F323) by the complaint investigation that concluded on August 17, 2011, as that is the only alleged noncompliance for which CMS proposes to impose an enforcement remedy. The only enforcement remedy at issue is the proposed \$10,000 PICMP. Petitioner's eligibility to conduct a NATCEP is also at issue.⁴ Jt. Stip.; Tr. 9. Whether the alleged noncompliance posed immediate jeopardy is not subject to review except to the extent that it is necessary to consider the severity of the alleged noncompliance when determining the reasonable enforcement remedies to be imposed.

I have carefully considered all the evidence and the arguments of both parties, although not all the evidence and arguments may be specifically discussed in this decision. I discuss the credible evidence given the greatest weight in my decision-making.⁵ I also discuss, as appropriate, the specific evidence I find not credible or that has little or no probative value. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given to every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

⁴ Petitioner stated at hearing that it was not conducting a NATCEP at the time of hearing and that the loss of eligibility was not the basis for requesting a hearing. It appears that the last NATCEP Petitioner conducted was in 1987. CMS Ex. 12 at 6; Tr. 10. Nevertheless, the loss of eligibility is at issue to the extent future eligibility to conduct a NATCEP may be affected by the resolution of this case.

⁵ "Credible evidence" is evidence "worthy of belief." *Black's Law Dictionary* 596 (8th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id.* at 1625.

- 1. Petitioner violated 42 C.F.R. § 483.25(h) (Tag F323) on June 21, 2011.**
- 2. Petitioner's violation of 42 C.F.R. § 483.25(h) (Tag F323) posed a risk for more than minimal harm.**
- 3. There is a basis for the imposition of an enforcement remedy.**

a. Facts

This case turns on facts related to the nature and amount of supervision required for Resident 2 and Resident 3 to prevent accidents, and the nature and amount of supervision that Petitioner provided. The incident on June 21, 2011 that triggered the deficiency citation occurred more than a month prior to the complaint investigation which began on July 28, continued on August 10, and was completed on August 17, 2011. Surveyor Esuerte found that on June 21, 2011, Resident 2 wandered into Resident 3's room; the residents pushed each other; and Resident 2 fell resulting in a fracture of the right orbital floor, subarachnoid hemorrhage, traumatic subdural hematoma, lacerated lip, and multiple contusions. The surveyor found that Resident 2 had a history of wandering and Resident 3 had a history of verbal and physical aggression with residents who wandered into her room. The surveyor alleges that Petitioner was deficient because staff failed to provide adequate supervision for both residents and failed to supervise Resident 3 after the accident. CMS Ex. 3 at 4-5. Surveyor Esuerte did not witness the incident and his factual findings were based on his review of resident records, staff interviews, and his observations of the facility. Tr. 34-40. I am not bound by Surveyor Esuerte's factual findings and put them aside and review the contemporaneous documentary evidence de novo. I conclude that in this case the most credible information regarding the assessed needs of the residents is found in the clinic records for Resident 2 and Resident 3.

Resident 2 and Resident 3 lived in "The Glen," Petitioner's dementia unit. The Glen is an L-shaped unit with restricted access. Jt. Stip. ¶¶ 7, 14. The nurses' station is located at the center of the unit, from which two wings extend at a 90-degree angle with resident rooms in each wing. The "day area" (also referred to as the "large dining room") is an open area across the hall from the nurses' station. The "small dining room" is a walled-off room adjacent to the nurses' station. CMS Ex. 11 at 30. The Glen was designed to house 32 residents in 19 rooms, but there were only 30 residents living in The Glen on June 21, 2011. Tr. 231-32.

The parties agree that at about 6:40 a.m. on June 21, 2011, Resident 2 was found on the floor in Resident 3's room with a moderate amount of blood on the floor. Resident 3 reported that Resident 2 pushed her and she pushed back. Petitioner's report on the accident states that the incident was Resident 3's reaction to another resident invading her space. The parties also agree that Resident 2 suffered a subarachnoid hemorrhage, a

traumatic subdural hematoma, multiple contusions, and a closed fracture of the orbital floor. Jt. Stip. ¶¶ 21-26; P. Ex. 33; CMS Ex. 8 at 23-25; CMS Ex. 11 at 1-2. It is not disputed that Resident 2 and Resident 3 were not subject to any direct supervision at approximately 6:40 a.m. on June 21, 2011, when the accident occurred. In fact, the parties have stipulated that none of Petitioner's staff saw Resident 2 enter Resident 3's room, and I infer that no staff member saw the accident occur. Jt. Stip. ¶ 20, 24.

Resident 2 had a history of wandering behavior, and at times was unable "to find own room, locate other areas of the facility, [or] identify key people . . ." Jt. Stip. ¶ 9. Resident 2 was assessed as suffering from dementia with anxiety and agitation; she took psychoactive medication; she had an impaired sense of balance and an unsteady gait; due to her cognitive impairment she had a poor ability to learn safety measures; and she had a history of falls, including one that resulted in a left shoulder fracture. Jt. Stip. ¶ 6; CMS Ex. 7 at 5-9. Her care plan to address her risk for falls required that she be monitored frequently as she could not use her call light; and an intervention added on June 14, 2010, and apparently not deleted or changed, required that she be kept within view of staff while awake. P. Ex. 20 at 1-2; CMS Ex. 7 at 7-8. Petitioner placed in evidence two different care plans that addressed Resident 2's wandering. Resident 2's wandering care plan effective October 5, 2010, includes an undated, hand-written entry that requires staff check the resident's location every shift but no requirement that her location be checked every 30 minutes. P. Ex. 20 at 4; CMS Ex. 7 at 6. Resident 2's wandering care plan effective October 6, 2010, required that staff check Resident 2's whereabouts every 30 minutes on each shift. P. Ex. 19 at 3; Jt. Stip. ¶ 12.

The parties stipulated that Resident 3 suffered from dementia with behavioral disturbance, agitation, progressive memory problems, and confusion and forgetfulness. The parties also stipulated that the resident's social services evaluations dated March 2010, March 2011, and May 2011, all stated that Resident 3 became angry and physically aggressive with anyone who invaded her space and warned that staff must continue to monitor the resident and other residents for intrusions upon Resident 3's personal space. Resident 3 was prescribed Risperdal®, an antipsychotic. Jt. Stip. ¶¶ 13-16, 18-19; CMS Ex. 8 at 4-6; CMS Ex. 13 at 44-49.

Resident 3 was admitted to Petitioner on July 2, 2009, with diagnosis of vascular dementia for which she was prescribed Risperdal®, 0.5 milligram (mg) as needed. P. Exs. 22-23. Anne Schnur, LPN, Director of The Glen, incorrectly testified that Resident 3 had not been prescribed Risperdal® as of April 23, 2010, when, in fact, the resident was on that medication at the time of her admission to Petitioner in July 2009. Tr. 204; P. Exs. 23 at 5-6, 25, 39. A nurse's note dated November 30, 2009, records that Resident 3 pushed another resident out of her room. CMS Ex. 8 at 7. A nurse's note dated February 11, 2010 states that Resident 3 pushed another resident out of her room. CMS Ex. 8 at 7. On February 19, 2010, Resident 3 pulled on the collar of another resident and warned her not to enter her room. CMS Ex. 8, at 8. Resident 3 became very angry and verbally

abusive when she was admonished not to touch other residents. On March 18, 2010, Resident 3 became angry and agitated when another resident was found in her room. The resident reported that Resident 3 pushed her to the floor. CMS Ex. 8 at 8. A monthly nursing summary dated April 23, 2010, states that Resident 3 had one episode of physical abuse, but no details are stated so it is not known whether this abuse involved another resident. P. Ex. 32 at 2; CMS Ex. 8 at 27.

On May 7, 2010, Resident 3 was sent to the hospital for a psychiatric evaluation due to an incident that involved Resident 3 touching another resident when ejecting the other resident from her room. Resident 3 was reported to be angry and upset. At the time, she was prescribed 0.25 mg of Risperidone (generic Risperdal®) twice daily as needed. After her return from the hospital, Resident 3 was reported to scream and yell at anyone who came her way. Her physician changed her order for Risperdal® from 0.5 mg as needed to 0.25 mg every 12 hours and ordered Ativan, an anti-anxiety drug, 0.5 mg twice a day as needed. P. Ex. 25 at 1-4, 6; P. Ex. 27; CMS Ex. 8 at 14-17. Progress notes show that Resident 3 was considered stable through August 30, 2010, and her Ativan was discontinued on August 2, 2010. P. Ex. 28. A monthly nursing summary dated December 23, 2010, states that the resident was easily upset. P. Ex. 29. A nurse's note dated December 31, 2010, states that Resident 3 held another resident's arm and told her to move but did not push. P. Ex. 30; CMS Ex. 8 at 18; Tr. 206-07. Resident 3's care plan in effect prior to the June 21, 2011 incident lists the incident on May 7, 2010 and also lists an incident on March 18, 2010. The care plan does not appear to have been updated based on the December 31, 2010 incident.

Resident 3's care plan required several interventions to address her anxiety and agitation, including her medications. According to Petitioner, Resident 3 was placed in a private room at the end of one of The Glen's halls to reduce the risk that other residents would enter Resident 3's room. CMS Ex. 11 at 30; Tr. 188; P. Br. 7. However, despite the social services' recommendations that the resident required supervision, Resident 3's care plan did not require supervision or observation of her interactions with other residents. P. Exs. 26, 31; Jt. Stip. ¶¶ 18-19; CMS Ex. 8 at 4-6.

The Medical Examiner for Cook County, Illinois determined that Resident 2 died on July 14, 2011, from the head injury she suffered in Resident 3's room on June 21, 2011. CMS Ex. 10.

b. Analysis

The general quality of care regulation, 42 C.F.R. § 483.25, requires that a facility ensure each resident receives necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the

resident's comprehensive assessment and plan of care. The quality of care regulations impose specific obligations upon a facility related to accident hazards and accidents. The applicable regulatory provision states:

The facility must ensure that –

- (1) The resident environment remains as free of accident hazards as is possible; and
- (2) Each resident receives adequate supervision and assistance devices to prevent accidents

42 C.F.R. § 483.25(h). CMS instructs its surveyors that the intent of 42 C.F.R. § 483.25(h)(1) and (2) is “to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.” The facility is expected to: identify, evaluate, and analyze hazards and risks; implement interventions to reduce hazards and risks; and monitor the effectiveness of interventions and modify them when necessary. State Operations Manual (SOM), CMS Pub. 100-07, app. PP, Guidance to Surveyors Long Term Care Facilities, F323 (Rev. 27; eff. Aug. 17, 2007).⁶

The Board has provided interpretative guidance for adjudicating alleged violations of 42 C.F.R. § 483.25(h)(1):

The standard in section 483.25(h)(1) itself -- that a facility “ensure that the environment is as free of accident hazards as possible” in order to meet the quality of care goal in section 483.25 -- places a continuum of affirmative duties on a facility. A facility must determine whether any condition exists in the environment that could endanger a resident's safety. If so, the facility must remove that condition if possible, and, when not possible, it must take action to protect residents from the danger posed by that condition. [Footnote omitted.] If a facility has identified and planned for a hazard and then failed

⁶ The SOM does not have the force and effect of law. However, the provisions of the Act and regulations interpreted by the SOM clearly do have such force and effect. *Ind. Dept. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

to follow its own plan, that may be sufficient to show a lack of compliance with [the] regulatory requirement. In other cases, an ALJ may need to consider the actions the facility took to identify, remove, or protect residents from the hazard. **Where a facility alleges (or shows) that it did not know that a hazard existed, the facility cannot prevail if it could have reasonably foreseen that an endangering condition existed either generally or for a particular resident or residents.**

Maine Veterans' Home – Scarborough, DAB No. 1975, at 6-7 (2005) (emphasis added).

The Board has also explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Ctr. – Riverchase*, DAB No. 2314, at 6-7 (2010); *Eastwood Convalescent Ctr.*, DAB No. 2088 (2007); *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd*, 281 F. App'x 180 (4th Cir. 2008); *Liberty Commons Nursing and Rehab. - Alamance*, DAB No. 2070 (2007); *Golden Age Skilled Nursing & Rehab. Ctr.*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Ctr.*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Ctr.*, DAB No. 1935 (2004); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The regulation does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigates foreseeable risks of harm from accidents. *Woodstock Care Ctr. v. Thompson*, 363 F.3d at 589 (noting a SNF must take “all reasonable precautions against residents’ accidents”). A facility is permitted the flexibility to choose the methods of supervision it uses to prevent accidents, but the chosen methods must be adequate under the circumstances. Whether supervision is “adequate” depends in part upon the ability of the resident to protect himself or herself from harm. *Id.* Based on the regulation and the cases in this area, CMS meets its burden to show a prima facie case if the evidence demonstrates that the facility failed to provide adequate supervision and assistance devices to prevent accidents, given what was reasonably foreseeable. *Alden Town Manor Rehab. & HCC*, DAB No. 2054, at 5-6, 7-12 (2006). An “accident” is an unexpected, unintended event that can cause a resident bodily injury, excluding adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions). SOM, app. PP, Tag F323; *Woodstock Care Ctr.*, DAB No. 1726, at 4.

The regulation gives Petitioner notice of the criteria or elements it must meet to comply with the program participation requirement established by the regulation. 5 U.S.C. §§ 551(4), 552(a)(1). Therefore, in order to make a prima facie showing of noncompliance, CMS must show that: (1) Petitioner violated the regulation by not complying with one or more of the requirements or elements of the regulation, which is a deficiency; and (2) the deficiency amounted to “noncompliance,” i.e., that Petitioner was not in substantial compliance because the deficiency posed a risk for more than minimal

harm.⁷ In this case, the elements of the CMS prima facie case established by 42 C.F.R. § 483.25(h) are: (1) an accident hazard existed within the resident's environment; (2) Petitioner failed to eliminate or mitigate the accident hazard to the extent possible; and (3) Petitioner failed to ensure a resident received supervision and assistive devices

⁷ In the final *Hillman* decision after remand, the Board explained:

The ALJ should be able to determine the existence of a prima facie case at the close of HCFA's presentation. Hence, as we pointed out in our first decision, HCFA would lose even if the provider offered no evidence at all, if HCFA did not come forward with evidence sufficient to support a conclusion in its favor in presenting its prima facie case. Thus, we held that HCFA must make its case "at the outset."

Once HCFA has established a prima facie case, the provider may then offer evidence in rebuttal, both by attacking the factual underpinnings on which HCFA relied and by offering evidence in support of its own affirmative arguments. An effective rebuttal of HCFA's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence.

* * * *

The major purpose of requiring HCFA to establish a prima facie case is to assure that the action taken by HCFA has a legally sufficient foundation, if the facts are determined to be as alleged by HCFA (since it would be unfair and inefficient to require a provider to defend against a case that, even if proven, would not suffice to support the action taken). In addition, we concluded that fairness requires HCFA to set out evidence of the factual basis for its action in order that the provider not have to offer a shot-gun defense without adequate notice to respond to the case against it. These purposes are accomplished once HCFA has presented a case sufficient, if not effectively rebutted, to sustain its action. At that point, HCFA has established a prima facie case and, to prevail, the provider must proceed to prove its case by the preponderance of the evidence on the record as a whole.

Hillman, DAB No. 1663 (internal citations omitted). HCFA was the predecessor to CMS.

necessary to prevent accidents. For noncompliance,⁸ CMS must also establish that the violation of 42 C.F.R. § 483.25(h) poses a risk for more than minimal harm. The regulations do not require that CMS show that an accident was foreseeable or that an accident occurred. The regulation establishes impossibility as a possible defense, i.e., Petitioner did all that was reasonably possible to mitigate or eliminate the risk but an accident occurred despite the steps taken. Board decisions also recognize a possible defense by providing that a facility is only responsible to eliminate or mitigate reasonably foreseeable risks for accidental injury. *Maine Veterans' Home – Scarborough*, DAB No. 1975, at 6-7.

CMS has presented sufficient evidence as to each element of its prima facie case to establish noncompliance, absent effective rebuttal. The CMS evidence shows that Resident 3 posed a risk for an unexpected, unintended event that could cause a resident bodily injury, i.e., an accident. The parties stipulated that Resident 3 suffered from dementia with behavioral problems. The parties also stipulated that social services evaluated her in March 2010, March 2011, and again in May 2011 as at risk to become angry and physically aggressive with anyone who invaded her personal space. Social services also recommended that Resident 3 and other residents be monitored to prevent intrusions upon Resident 3's personal space. Jt. Stip. ¶¶ 13-16, 18-19; CMS Ex. 8 at 4-6; CMS Ex. 13 at 44-49. There is no dispute that on June 21, 2011, Resident 2 and Resident 3 were together in Resident 3's room with no staff members present and the residents were unmonitored or unsupervised, either by direct observation of staff or by some monitoring device. Jt. Stip. ¶¶ 20, 24. The parties stipulated that Resident 2 was found on the floor of Resident 3's room with actual injuries that amounted to more than minimal harm. Jt. Stip. ¶¶ 21-26; CMS Ex. 8 at 23-25; CMS Ex. 11 at 1-2. I conclude that this evidence is sufficient to establish a prima facie case of noncompliance based on violation of 42 C.F.R. § 483.25(h).⁹ CMS also argues at length that Petitioner did not provide adequate supervision of Resident 3 immediately following the June 21, 2011

⁸ Noncompliance is “any deficiency that causes a facility to not be in substantial compliance,” which is “a level of compliance . . . such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.” 42 C.F.R. § 488.301.

⁹ While the “accident” itself in this case is not a basis for finding Petitioner was not in substantial compliance, the occurrence of the accident identifies the accident hazard, and the facts and circumstances of the accident are evidence reflecting upon the adequacy of Petitioner's supervision of the two residents. *Lake Park Nursing & Rehab. Ctr.*, DAB No. 2035, at 8 (2006) (citing *St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964 (2005)).

incident. CMS Br. 11-17. However, because I find that Petitioner was not in substantial compliance based on the events leading up to the incident, I need not and do not address Petitioner's conduct immediately following the accident.

Thus, review shifts to determining whether Petitioner either rebutted the CMS prima facie case by showing that adequate supervision or other interventions were implemented to mitigate or eliminate the risk for occurrence of the accident or any potential harm; that it was impossible to eliminate or mitigate this accident risk; or that the accident risk posed by Resident 3 was unforeseeable.

Petitioner argues that CMS failed to make its prima facie case. P. Br. at 1, 11. I have already rejected this argument but consider whether or not Petitioner has rebutted any of the elements of the CMS prima facie case. Based on the foregoing analysis, giving due consideration to Petitioner's arguments, I conclude that Petitioner did not rebut the CMS prima facie case. Petitioner stipulated that Resident 3 posed a risk for physical aggression to any resident who wandered into her room, and that social services assessed that monitoring of the resident and other residents was required to avoid such incidents; that Resident 2 and 3 were alone and unmonitored on June 21, 2011; and that Resident 2 suffered actual harm. Jt. Stip. ¶¶ 18-22. Therefore, Petitioner stipulated to the prima facie case.

Petitioner argues that the surveyor imposed an incorrect standard related to supervision. P. Br. at 12-13. The surveyors' understanding, or lack thereof, of the supervision of residents required by 42 C.F.R. § 483.25(h) is not at issue before me, except to the extent that it may reflect upon the credibility of the surveyor's opinions and testimony. I am not bound by Surveyor Esuerte's opinions and conclusions but weigh them as I would any other evidence in the case. I am required to provide Petitioner a de novo review of the evidence and the application of the law and policy to the facts I find. Rather than attempt to weigh the various opinions and conclusions of Surveyor Esuerte, I have elected to simply put them aside as I did with his findings fact.

Petitioner erroneously argues that the June 21, 2011 accident was not foreseeable. P. Br. at 11-20; P. Reply at 2-12. The parties stipulated that Resident 3 suffered from dementia with behavioral disturbance and agitation. The parties also stipulated that the resident's social services evaluations dated March 2010, March 2011, and May 2011, all stated that Resident 3 became angry and physically aggressive with anyone who invaded her space. The social services evaluation also assessed Resident 3 as being in need of supervision in the form of monitoring by staff and warned that other residents should be monitored to prevent intrusions upon Resident 3's personal space. Jt. Stip. ¶¶ 13, 18-19; CMS Ex. 8 at 4-6. Social services certainly foresaw the possibility that Resident 3 could become personally aggressive and warned Petitioner of this possibility three times between March 2010 and May 2011. The evidence also shows that Resident 3 was physically aggressive with residents on November 30, 2009, February 11, 2010, February 19, 2010, March 18,

2010, May 7, 2010, and December 31, 2010. CMS Ex. 8 at 7, 8, 14-18. Resident 3 was discharged from Saint Frances Hospital and first admitted to Petitioner on about July 2, 2009. Her discharge orders required that she receive Risperidone, 0.5 mg, as needed for agitation at least through August 30, 2009. P. Ex. 23 at 5-6, 39. Resident 3's care plan shows that she was to receive 0.5 mg of Risperdal® daily as needed for agitation beginning July 21, 2009. P. Ex. 26 at 3. Petitioner has provided me no evidence that the Risperidone was stopped between July 2009 and May 2010 and the care plan reflects no change was made to her medication until May 7, 2010. P. Ex. 26 at 3. Following her May 7, 2010, discharge from the hospital where she had undergone a psychiatric evaluation following being physically aggressive with another resident who entered her room, Resident 3's discharge orders required Risperidone, 0.25 mg every 12 hours as needed. P. Ex. 25 at 2; P. Ex. 27. However, three days later on May 20, 2010, Resident 3 was again agitated and yelling and screaming and the physician changed her medications, discontinuing the 0.25 mg of Risperidone every 12 hours as needed and ordering Risperidone, 0.25 mg every 12 hours and 0.5 mg of Ativan twice per day. P. Ex. 27 at 2. The Ativan was discontinued on August 2, 2010. P. Ex. 28. The evidence shows no incident of physical aggression until December 31, 2010 when, according to the evidence before me, Resident 3 was still receiving Risperdal twice a day rather than just as needed which was the order prior to May 20, 2010. The fact that Resident 3 was physically aggressive on December 31, 2010, while receiving the regular dose of Risperidone clearly put Petitioner on notice that the medication alone was not sufficient to prevent the resident's aggression. Social services clearly recognized the continuing risk posed by Resident 3 and so advised Petitioner by its evaluation on May 23, 2011. CMS Ex. 8 at 6; P. Ex. 31 at 3. Petitioner acknowledges and does not dispute the May 23, 2011 social services assessment. P. Br. at 8. I find that all the social services assessments are credible and worthy of weight.¹⁰ The copy of Resident 3's care plan offered as evidence by Petitioner shows no changes to interventions following the December 31, 2010 incident. The December 31 incident should have clearly put Resident 3's care-planning team and Petitioner on notice that the existing interventions, including the Risperidone, were insufficient to eliminate or adequately mitigate the risk for physical aggression by Resident 3. Petitioner should have some evidence that the care-planning team considered the interventions in effect on December 31 and determined to modify, substitute, or continue interventions in light of the December 31

¹⁰ The consistency of the phraseology of the three assessments may cause some initial concern that a form or computer template was used that simply reproduced similar language for all three assessments. However, upon closer examination it is apparent that there are differences in the text that support a conclusion that the assessments are, in fact, distinct. Petitioner does not object to the assessments and offered no evidence to show that they are erroneous or otherwise not credible.

incident. Petitioner has not presented such evidence. The May 23, 2011 social services assessment should have further emphasized for the care-planning team and Petitioner that Resident 3 presented a risk for physical aggression against any resident that entered her personal space. Accordingly, I conclude that after December 31, 2010, it was clearly foreseeable that any resident that entered Resident 3's room was at risk for harm due to physical aggression by Resident 3, despite care-planned interventions. Contrary to the suggestion of Petitioner (P. Reply at 3), it is not necessary that a specific accident or specific type of harm be foreseeable. Rather, the care planning team had more than sufficient notice as of December 31, 2010, of the risk for possible physical aggression by Resident 3 against another resident. Petitioner is obliged by the regulation to identify accident hazards that pose a risk for harm to its residents and then take action to mitigate or eliminate the accident hazard. It was clearly foreseeable after December 31, 2010, that Resident 3 could cause harm to any resident that entered her room and that was sufficient to trigger Petitioner's duty to act under 42 C.F.R. § 483.25(h) and implement new interventions or revise existing interventions to protect its residents from the risk.

Petitioner argues it proved it was in substantial compliance and its interventions were reasonable given the foreseeable risk. P. Br. at 11-20; P. Reply at 2-12. Petitioner's argument is not supported by the evidence. Social services assessed Resident 3 as posing a risk for physical aggression against any resident that entered her personal space. Social services assessed Resident 3 as requiring monitoring to mitigate or eliminate the risk for physical aggression. The social services assessments occurred in March 2010, March 2011, and May 2011. Resident 3's plan of care offered as evidence by Petitioner reflects effective dates in July 2009 when Resident 3 was admitted to Petitioner. The copy of the care plan shows that it was printed in July 2009 and includes hand-written entries dated between October 8, 2009 and December 17, 2010. The care plan does not reflect that Resident 3 was assessed as being potentially physically aggressive with other residents. The care plan also does not list an intervention that required that staff supervise Resident 3 and monitor her interactions with other residents. The care plan also fails to indicate that the possibility of physical aggression by Resident 3 was highest when another resident entered her room and the care plan lists no interventions to address that risk. P. Ex. 26.

Similarly, Petitioner has not shown that Resident 2's care plan was followed. Resident 2's care plan reflected that she was prone to wander and, with her unsteady gait and impaired balance, she was assessed as at risk for injury due to accidental falls and she had fallen in the past with resulting injury. Her care plan required that staff check her location every 30 minutes on each shift. Jt. Stip. at 9, 12; P. Ex. 19 at 3; P. Ex. 20 at 4; CMS Ex. 7 at 6. I agree with Petitioner that the Act and the regulations do not specify that a facility provide one-to-one supervision or that a facility document the delivery of supervision. P. Br. at 13-14. Indeed, it is well-accepted that the regulations do not tell facilities how they must deliver care and services; rather, a facility is permitted discretion to determine how to deliver care and services to best meet the needs of residents.

Woodstock Care Ctr., 363 F.3d at 589. However, when a facility fails to require staff to document how care and services were delivered, the facility is challenged in a case like this to meet its burden to show that the care and services were actually delivered consistent with the care planned needs of the resident. Resident 2 provides an excellent example. Despite some inconsistencies in her care plan,¹¹ it is clear from the care plan that Resident 2 required regular supervision to mitigate or eliminate her risk for falls. On June 21, 2011, Resident 2 fell in Resident 3's room and suffered injuries. Petitioner's staff failed to document and Petitioner can now not prove that Resident 2 was receiving the supervision that her care planning team ordered for her. LPN Schnur's testimony that staff watched residents on The Glen all the time but they do not document every observation does not satisfy Petitioner's burden. Even with maximum staff of six during the morning, it may be inferred that not all 30 residents and 19 rooms can be visualized all the time. For example, LPN Schnur agreed that it was not possible to see into resident rooms particularly when staff was required to be in the dining room and the small dining room could not be observed from the nurses' station. P. Br. at 4; Tr. 188-90, 193-95, 233. Though I accept LPN Schnur's assertion that there was not a time when she was on duty that she did not see every resident at least every 30 minutes, she worked the day shift and she did not testify that those in charge of other shifts were so conscientious. Tr. 194-95. I note that LPN Schnur testified that interventions for individual residents are communicated to staff by care plans. As previously noted, Resident 2's fall risk care plan required that she be monitored frequently and that she be kept in view of staff while awake. P. Ex. 20 at 1-2; CMS Ex. 7 at 7-8. One care plan for wandering dated October 5, 2010, required that her location be checked every shift by staff but another care plan dated October 6, 2010 required that her location be checked every 30 minutes. P. Ex. 20 at 4; CMS Ex. 7 at 6; P. Ex. 19 at 3. The inconsistency of these interventions makes it difficult for staff, who rely upon care plans for guidance, to know what supervision is actually required; shows that the interventions are not reasonable to achieve their purpose; and strongly suggests that the care planning team failed in its duties – though a care planning deficiency was not cited.

Petitioner expresses concern about Surveyor Esuerte's reliance upon his interview of Anetka Mroz, a Rehabilitation Staff Member at Petitioner's facility. I find that Ms. Mroz's hearsay statements to Surveyor Esuerte do not bear sufficient indicia of reliability to merit any weight. Surveyor Esuerte testified that he did not ask Ms. Mroz whether she personally witnessed the alleged incidents of aggression she told him about; he did not ask her exactly when the alleged incidents of aggression occurred; he admitted that he reviewed the facility records and found no record of the alleged incidents of aggression

¹¹ I recognize that Petitioner was not cited for a deficiency related to care planning or failure to document.

and he simply concluded that Petitioner failed to document the incidents but did not cite Petitioner for either failure to investigate or failure to document the incidents; and he admitted that he did not ask Ms. Mroz whether or not she reported the incidents of aggression to nursing staff or management and, if not, why not. Ms. Mroz was not under oath when she made her statement to Surveyor Esuerte, and he did not reduce her statement to writing and request that she verify its accuracy and attest to the statement.¹² Accordingly, I conclude that the reported statements of Ms. Mroz lack sufficient indicia of reliability to merit any weight in reaching this decision and they are not considered for any purpose.¹³

Petitioner argues that if I conclude that Petitioner was not in substantial compliance with program participation requirements, the deficiency did not pose immediate jeopardy. P. Br. at 11. Whether or not the declaration of immediate jeopardy was clearly erroneous is not an issue in this case as neither the PICMP nor the loss of NATCEP authority would be affected by a decision that the declaration of immediate jeopardy was clearly erroneous. 42 C.F.R. § 498.3(b)(14), (d)(10)(i); *Fort Madison Health Ctr.*, DAB No. 2403, at 12-13 (2011) (recognizing that substantive review of an immediate jeopardy determination is not available if CMS proposes only a PICMP).

Accordingly, I conclude that CMS has made a prima facie showing of a violation of 42 C.F.R. § 483.25(h) that posed a risk for more than minimal harm. Petitioner has failed to rebut the prima facie showing or to establish an affirmative defense by a preponderance of the evidence.

¹² Survey protocols do not require that surveyors obtain sworn or affirmed statements from individuals they interview in pursuit of their investigations. I do not mean to suggest that Surveyor Esuerte committed any error by failing to obtain a sworn or affirmed written statement from Ms. Mroz. However, in determining the weight to be accorded to out-of-court statements offered as substantive evidence, the fact that the statement was not written by the declarant, or at least adopted by the declarant, and sworn or affirmed, is appropriately considered as a factor affecting the reliability of the statements and the reliability of the recollection of the statement in this proceeding.

¹³ Petitioner claims that CMS surprised Petitioner at hearing by introducing the Mroz statement for the first time. P. Br. 18. Petitioner implies bad faith, stating “[n]either CMS nor the surveyor ever disclosed this alleged statement anytime before the hearing and it was never otherwise documented in any material that was produced prior to hearing.” P. Reply Br. 5. In fact, CMS relied on the Mroz statement in its prehearing brief. CMS Prehr’g Br. 11. The record, therefore, shows that CMS did not knowingly conceal this statement or “surprise” Petitioner at hearing.

4. The proposed enforcement remedy of a \$10,000 PICMP is reasonable.

5. Petitioner's ineligibility to conduct a NATCEP is mandatory.

I have concluded that Petitioner was not in substantial compliance with program participation requirements due to a violation of 42 C.F.R. § 483.25(h) that posed a risk for more than minimal harm on June 21, 2011. If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a per-day CMP for the number of days that the facility is not in compliance or a PICMP for each instance that a facility is not in substantial compliance, regardless of whether the deficiencies pose immediate jeopardy. 42 C.F.R. § 488.430(a). Here, CMS proposes to impose a PICMP of \$10,000 for the instance of noncompliance on June 21, 2011. Petitioner's noncompliance provides a basis for the imposition of an enforcement remedy. The CMP that CMS proposes is the maximum permissible in the range of authorized PICMPs. 42 C.F.R. §§ 488.408, 488.438.

When I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy and the remedy proposed is a CMP, my authority to review the reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations include: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including but not limited to the facility's neglect, indifference, or disregard for resident care, comfort, and safety and the absence of culpability is not a mitigating factor. The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm, no actual harm with the potential for more than minimal harm, but not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health and safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is de novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within

reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800, at 10; *CarePlex of Silver Spring*, DAB No. 1683, at 14-16 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

CMS presented evidence that Petitioner was previously found not in substantial compliance due to a violation of 42 C.F.R. § 483.25(h) (Tag F323) but with no actual harm or immediate jeopardy, during a survey in July 2010. The CMS evidence also shows that noncompliance was found during surveys in July 2009 and July 2008, due to violations of different regulations but none with actual harm or immediate jeopardy. CMS Ex. 17. Petitioner did not offer evidence reflecting upon its financial condition or its ability to pay the proposed PICMP. CMS submitted a Financial and Statistical Report (Cost Report) for Long-Term Care Facilities for fiscal year 2010 that Petitioner submitted to the State of Illinois Department of Healthcare and Family Services. CMS Ex. 16. The document submitted by CMS indicates that in 2010, a \$10,000 PICMP was not likely to force Petitioner into bankruptcy. But the document tells me nothing about Petitioner's ability to pay in 2011 or now and the document has little or no relevance. Because Petitioner has not alleged an inability to pay, I conclude there is no issue in that regard.

Petitioner argues that it was not culpable for errors and omissions related to the accident on June 21, 2011, although it does so in the context of arguing any noncompliance was not immediate jeopardy. P. Br. 21-22. Petitioner also argues that the circumstances giving rise to its noncompliance were "isolated" and "unique," P. Br. 21, which I construe to be an argument that the "seriousness of the deficiencies" was not such as to warrant the maximum permissible PICMP. The regulation defines, "culpability" as "neglect, indifference, or disregard for resident care, comfort, and safety." 42 C.F.R. § 488.438(f)(4). Petitioner is culpable for not planning for and providing adequate supervision to both residents. Petitioner is particularly culpable in the case of Resident 3 because it was clear in December 2010 that the resident's care plan was insufficient to mitigate or eliminate the risk that she would become physically aggressive and social services highlighted the risk in its March and May 2011 reports, but Resident 3's care plan reflects no changes. I conclude that Petitioner's inaction reflects a high level of neglect, indifference or disregard for its resident's safety.

It is not disputed that Resident 2 died as a result of the injuries sustained when she fell in Resident 3's room. CMS Ex. 10 at 6. When a facility's deficient conduct results in a resident's death, the seriousness of its noncompliance is arguably severe. Here, Petitioner did not provide adequate supervision to prevent the accident that resulted in a resident's death.

Considering the facility's history of noncompliance, the level of culpability, and the death of Resident 2 as a result of Petitioner's noncompliance, imposition of the highest permissible PICMP is not unreasonable, particularly given that that amount is only \$10,000. While the surveyor determined that the incident was isolated as indicated by the

